400 Lakebridge Plaza Drive
Ormond Beach, Fl. 32174
Phone # (386) 677-9044
Fax# (386) 677-3083

RELEASE OF MEDICAL RECORDS

I, ________________________________ authorize Parks Dermatology Center to Release my medical records relating to my care at Parks Dermatology Center to _________________________________.
Please Mail___or Fax ____ the following:

- ☐ Labs
- ☐ Pathologies
- ☐ P/H History
- ☐ OP Notes
- ☐ Progress Notes

TO:

Myself: _______________________________
Name & Address: ____
City, State & Zip: ____
Phone/Fax #: ____

Name of Dr. or Facility: ____
Name & Address: ____
City, State & Zip: ____
Phone/Fax #: _____________________________

Please Print Name & D.O.B.____

Signature: ____